APPENDIX 27
CASE MANAGEMENT AND REHABILITATIVE SERVICES

I. MENTAL HEALTH CASE MANAGEMENT SERVICES

A. MH Case Management Services.

(a) MH case management services assist an enrollee in gaining and coordinating access to necessary care and services appropriate to the enrollee's needs. There are two types of MH case management services:

(1) routine MH case management, for an adult, a child, or adolescent, which is primarily site-based; and

(2) intensive MH case management, for a child or adolescent, which is primarily community-based.

(b) A case manager assigned to an enrollee who is authorized to receive routine MH case management services must:

(1) meet face-to-face with the enrollee, and the enrollee's LAR or primary caregiver if the enrollee is a child or adolescent, within 14 days after the case manager is assigned to the enrollee;

(2) meet face-to-face with the enrollee upon the request of the enrollee, the LAR, or the primary caregiver at the case manager's work site or document why the meeting did not occur;

(3) assist the enrollee in identifying the enrollee's immediate need in gaining access to a community resource that may address that need;

(4) document the identified need and the assistance given to address the identified need; and

(5) if notified that the enrollee is in crisis, coordinate with the appropriate providers of emergency services to respond to the crisis, as described in Title 25, Texas Administrative Code (“TAC”), Chapter 412, Subchapter G, §412.314 of this title (relating to Crisis Services).

(c) A case manager assigned to an enrollee who is authorized to receive intensive MH case management services must:

(1) meet face-to-face with the enrollee and the enrollee's LAR or primary caregiver within seven days after the case manager was assigned to the enrollee or within seven days after discharge from an inpatient psychiatric setting, whichever is later or document the reasons the meeting did not occur;

(2) meet face-to-face with the enrollee and the enrollee's LAR or primary caregiver in accordance with the enrollee's MH case management plan or document why the meeting did not occur;

(3) meet face-to-face with the enrollee and the enrollee's LAR or primary caregiver upon notification of a clinically significant change in the enrollee's functioning, life status, or service needs or document why the meeting did not occur;

(4) meet face-to-face with the enrollee and the enrollee's LAR or primary caregiver at the request of the enrollee, the LAR, or primary caregiver or document why the meeting did not occur;

(5) gather information about the enrollee's strengths and service needs across life domains from relevant sources, including:

(A) the enrollee;

(B) the enrollee's LAR or primary caregiver;

(C) other agencies and organizations providing services to the enrollee;

(D) the enrollee's clinical record; and

(E) other sources identified by the LAR or primary caregiver;

(6) utilize wraparound planning to develop an MH case management plan that addresses the enrollee's unmet needs across life domains and that includes:

(A) a prioritized list of the enrollee's unmet needs;

(B) a description of the objective and measurable outcomes for each of the unmet needs;

(C) a description of the actions the enrollee, the case manager, and other designated people will take to achieve those outcomes;

(D) a list of the necessary services and service providers;

(E) a description of the MH case management services to be provided by the case manager; and

(F) a statement of the maximum period of time between face-to-face contacts with the enrollee, and the enrollee's LAR or primary caregiver, determined in accordance with the utilization management guidelines;

(7) assist the enrollee in gaining access to the needed services and service providers including:

(A) making referrals to potential service providers;

(B) initiating contact with potential service providers;

(C) arranging initial meetings and non-routine appointments;

(D) arranging transportation to ensure the enrollee's attendance;

(E) advocating with service providers; and

(F) providing relevant information to service providers;

(8) monitor the enrollee's progress toward the outcomes set forth in the MH case management plan including;

(A) gathering information from the enrollee, current service providers, and other resources;

(B) reviewing pertinent documentation, including the enrollee's clinical records, and assessments;

(C) ensuring the MH case management plan was implemented as agreed upon;

(D) ensuring needed services were provided;

(E) determining if progress toward the desired outcomes was made;

(F) identifying barriers to accessing services or to obtain maximum benefit from services;

(G) advocating for the modification of services to address changes in the needs or status of the enrollee;

(H) identifying emerging unmet service needs;

(I) determining if the MH case management plan needs to be modified to address the enrollee's unmet service needs more adequately; and

(J) revising the MH case management plan as necessary to address the enrollee's unmet service needs**;**

(9) upon notification that the enrollee is in crisis, coordinate with the appropriate providers of emergency services to respond to the crisis, as described in Title 25, TAC, Chapter 412, Subchapter G, §412.314; and

(10) recognize that the LAR is authorized to act on behalf of the child or adolescent.

B. Service Limitations.

(a) A case manager may not provide MH case management services to his or her child, parent, spouse, mother-in-law, father-in-law, son-in-law, daughter-in-law, stepchild, stepparent, grandchild, or sibling.

(b) Activities that do not constitute MH case management services are identified in the DSHS MH Case Management Services Billing Guidelines, referenced as Exhibit C in Title 25, TAC, Chapter 412, Subchapter I, §412.415 (relating to Exhibits).

C. Staff Qualifications.

(a) A case manager must be:

(1) a QMHP-CS or a CSSP;

(2) an employee of the provider; and

(3) trained in accordance with Section I.D.

(b) The provider may require additional education and experience for a case manager.

(c) A staff member who supervises a case manager must:

(1) be a QMHP-CS;

(2) be an employee of the provider;

(3) be trained in accordance with Section I.D; and

(4) have experience providing MH case management services.

D. Staff Training.

(a) A case manager and a supervisor of a case manager must receive training and demonstrate competency in the following areas:

(1) the nature of mental illness and serious emotional disturbance;

(2) the dignity and rights of an enrollee;

(3) interacting with an enrollee who has a special physical need such as a hearing or visual impairment;

(4) responding to an enrollee's language and cultural needs through knowledge of customs, beliefs, and values of various, racial, ethnic, religious, and social groups;

(5) identifying, preventing, and reporting abuse and neglect;

(6) the requirements of this subchapter;

(7) the uniform assessment;

(8) the utilization management guidelines;

(9) developing and implementing an MH case management plan;

(10) identifying an enrollee in crisis;

(11) appropriate actions to take in managing a crisis;

(12) co-occurring psychiatric and substance use disorders, as described in Title 25, TAC, Chapter 411, Subchapter N of this title (relating to Standards for Services to Persons with Co-Occurring Psychiatric and Substance Use Disorders);

(13) the developmental needs of children, adolescents, and adults;

(14) the wraparound planning process approved by the State, if the case manager is providing intensive MH case management services to a child or adolescent;

(15) health and human services available to children as described in Texas Government Code §531.0244, if the case manager is providing intensive MH case management services to a child or adolescent;

(16) the availability of resources within the local community; and

(17) strategies for advocating effectively for enrollees.

(b) The provider must document the training, competencies, and experience in the personnel record of each case manager and a supervisor of a case manager who received the training described in this section.

E. Documentation of MH Case Management Services.

(a) A case manager must document the provision of MH case management services as follows:

(1) if the service involves face-to-face contact with the enrollee, document:

(A) the date of the contact;

(B) start and stop time of the contact;

(C) a description of the MH case management service provided;

(D) the enrollee's response to the services being provided;

(E) if the enrollee is receiving intensive MH case management services, the progress or lack of progress in addressing the enrollee's outcomes as identified in the MH case management plan; and

(F) the case manager's signature and credentials of QMHP-CS or CSSP;

(2) if the service does not involve face-to-face contact with the enrollee, document:

(A) the date(s) of the service;

(B) a description of the MH case management service provided;

(C) if the service involves face-to-face or telephone contact, the person with whom the contact was made;

(D) the outcome of the service; and

(E) the case manager's signature and credentials of QMHP-CS or CSSP.

(b) The provider must retain documentation in compliance with applicable federal and state laws, rules, and regulations.

F. Medicaid Reimbursement.

(a) A provider may file a claim for Medicaid MH case management services, if a billable event occurs. A billable event is a face-to-face contact between an enrollee and a case manager who provides an MH case management service:

(1) during the contact; and

(2) in accordance with Section I.A.

(b) A unit of service for MH case management services is 15 continuous minutes.

(c) The Contractor will not reimburse a provider for Medicaid MH case management services if:

(1) the service provided was an integral and inseparable part of another service;

(2) the service was provided by a person who was not qualified in accordance with Section I.D of this Appendix __;

(3) the service provided was not the type, amount, and duration authorized by Contractor or its designee; or

(5) the service was not provided or documented in accordance with this Appendix __.

(d) The Contractor will not reimburse a provider for Medicaid MH case management services for coordination activities that are included in the provision of:

(1) rehabilitative crisis intervention services, as defined in Section II.A;

(2) psychosocial rehabilitation services, as defined in Section II.C.

(e) If Medicaid-funded MH case management services are continued prior to a fair hearing, as required by Title 1, TAC, §357.7 (relating to Maintaining Benefits or Services), the provider may file a claim for such services.

II. REHABILITATIVE SERVICES

A. Crisis Intervention Services.

(a) Description. Crisis intervention services are interventions provided in response to a crisis in order to reduce symptoms of severe and persistent mental illness or serious emotional disturbance and to prevent admission of an enrollee to a more restrictive environment. Crisis intervention services include:

(1) an assessment of dangerousness of the enrollee to self or others;

(2) the coordination of emergency care services in accordance with Title 25, TAC, 412G, §412.314;

(3) behavior skills training to assist the enrollee in reducing stress and managing symptoms;

(4) problem-solving;

(5) reality orientation to help the enrollee identify and manage their symptoms of mental illness; and

(6) providing guidance and structure to the enrollee in adapting to and coping with stressors.

(b) Conditions.

(1) Crisis intervention services may be provided to:

(A) an adult; or

(B) a child or adolescent.

(2) Crisis intervention services must be provided one-to-one.

(3) Crisis intervention services may be provided:

(A) on-site; or

(B) in-vivo.

(4) Crisis intervention services must be provided by a QMHP-CS.

(5) Crisis intervention services may not be provided to an enrollee who is currently admitted to a CSU.

(7) Crisis intervention services may be provided without a treatment plan described in 25 TAC Chapter 419, Subchapter L, §419.456(b).

B. Medication Training and Support Services.

(a) Description. Medication training and support services are training based on curricula promulgated by DSHS, which is referenced as Exhibit C in Title 25, TAC, Chapter 419, Subchapter L, §419.468 of this title (relating to Exhibits), to assist an enrollee in:

(1) understanding the nature of an adult's severe and persistent mental illness or a child or adolescent's serious emotional disturbance;

(2) understanding the role of the enrollee's prescribed medications in reducing symptoms and increasing or maintaining the enrollee's functioning;

(3) identifying and managing the enrollee's symptoms and potential side-effects of the enrollee's medication;

(4) learning the contraindications of the enrollee's medication;

(5) understanding the overdose precautions of the enrollee's medication; and

(6) learning self-administration of the enrollee's medication.

(b) Conditions.

(1) Medication training and support services may be provided to:
(A) an adult;
(B) a child or adolescent; or
(C) the LAR or primary caregiver of a child or adolescent.

(2) Medication training and support services provided to an adult may be provided:
(A) in a group; or
(B) one-to-one.

(3) Medication training and support services provided to a child or adolescent may be provided:
(A) in a group; or
(B) one-to-one, except that the LAR or primary caregiver may also be present.

(4) Medication training and support services provided to an LAR or primary caregiver may be provided:
(A) in a group; or
(B) one-to-one, except that the child or adolescent may also be present.

(5) Medication training and support services may be provided:
(A) on-site; or
(B) in-vivo.

(6) Medication training and support services provided to an adult must be provided by:
(A) a QMHP-CS;
(B) a CSSP;
(C) a peer provider; or
(D) a licensed medical personnel.

(7) Medication training and support services provided to a child, adolescent, LAR, or primary caregiver must be provided by:
(A) a QMHP-CS;
(B) a CSSP; or
(C) a licensed medical personnel.

(8) Medication training and support services may not be provided to an enrollee who is currently admitted to a CSU.

(c) Frequency and duration. The provision of medication training and support services must be in accordance with the amount and duration for which the Medicaid provider has obtained authorization.

C. Psychosocial Rehabilitation Services.

(a) Description. Psychosocial rehabilitation services are social, educational, vocational, behavioral, and cognitive interventions provided by members of an enrollee's therapeutic team that address deficits in the enrollee's ability to develop and maintain social relationships, occupational or educational achievement, and independent living skills that are the result of a severe and persistent mental illness in adults. Psychosocial rehabilitation services may also address the impact of co-occurring disorders upon the enrollee's ability to reduce symptomology and increase daily functioning. Psychosocial rehabilitation services consist of the following component services:

(1) independent living services;
(2) coordination services;
(3) employment related services;
(4) housing related services;
(5) medication related services; and
(6) crisis related services.

(b) Conditions.

(1) Psychosocial rehabilitative services:

(A) may only be provided to an adult;
(B) may be provided one-to-one or in a group;
(C) may be provided on-site or in-vivo;
(D) must be provided by a member of the enrollee's therapeutic team; and
(E) may not be provided to an enrollee who is currently admitted to a CSU.

(2) Independent living services, coordination services, employment related services, and housing related services, as described in subsection (c)(1)-(4) of this section, must be provided by:

(A) a QMHP-CS;
(B) a CSSP; or
(C) a peer provider.

(3) Medication related services, as described in subsection (c)(5) of this section, must be provided by a licensed medical personnel.

(4) Crisis related services, as described in subsection (c)(6) of this section, must be provided by a QMHP-CS.

(5) As part of the provision of coordination services described in subsection (c)(2) of this section, a QMHP-CS must conduct the uniform assessment at intervals specified by the State to determine the type, amount, and duration of Medicaid MH rehabilitative services.

(c) Components of psychosocial rehabilitation services.

(1) Independent living services assist an enrollee in acquiring the most immediate, fundamental functional skills needed to enable the enrollee to reside in the community and avoid more restrictive levels of treatment. Such services include training in symptom management, personal hygiene, nutrition, food preparation, exercise, and community integration activities.

(2) Coordination services assist an enrollee in gaining and coordinating access to necessary care and services appropriate to the needs of the enrollee. Such services include:

(A) assessment of the enrollee to determine the enrollee's need for services (e.g., medical, educational, social, or substance use services), which includes the administration of the uniform assessment;
(B) treatment planning with the enrollee to develop goals and identify a course of action to respond to the assessed needs;
(C) referral to the appropriate medical, social, educational, substance use providers or other programs and services;
(D) referral to support services and advocacy groups; and

(E) monitoring and follow-up to ensure that the treatment plan developed in accordance with Title 25, TAC, Chapter 412, Subchapter G, §412.315(b) and (c) (relating to Assessment and Treatment Planning) is implemented effectively and adequately addresses the needs of the enrollee.

(3) Employment related services provide supports and skills training that are not job-specific and focus on developing skills to reduce or manage the symptoms of mental illness that interfere with an enrollee's ability to make vocational choices or obtain or retain employment. Such services include:

(A) instruction in dress, grooming, socially acceptable behaviors, and etiquette necessary to obtain and retain employment;

(B) training in task focus, maintaining concentration, task completion, and planning and managing activities to achieve outcomes;

(C) instruction in obtaining appropriate clothing, arranging transportation, utilizing public transportation, accessing and utilizing available resources related to obtaining employment, and accessing employment-related programs and benefits (e.g., unemployment, workers compensation, and Social Security);

(D) interventions or supports provided on or off the job site to reduce behaviors or symptoms of mental illness that interfere with job performance or that interfere with the development of skills that would enable the enrollee to obtain or retain employment; and

(E) interventions designed to develop natural supports on or off the job site to compensate for skill deficits that interfere with job performance.

(4) Housing related services develop an enrollee's ability to manage the symptoms of the enrollee's mental illness that interfere with the enrollee's ability to obtain or maintain tenure in independent integrated housing. Such services include:

(A) skills training related to:

(i) home maintenance and cleanliness;

(ii) problem-solving with the enrollee's landlord and neighbors; and

(iii) maintaining appropriate interpersonal boundaries; and

(B) supportive contacts with the enrollee to reduce or manage the behaviors or symptoms related to the enrollee's mental illness that interfere with maintaining independent integrated housing.

(5) Medication related services provide training regarding an enrollee's medications in order to increase the enrollee's adherence to medication treatment. Such services include training in:

(A) the self-administration of the enrollee's medication;

(B) the importance of the enrollee taking the medications as prescribed;

(C) determining the effectiveness of the enrollee's medications; and

(D) identifying side-effects of the enrollee's medications.

(6) Crisis related services respond to an enrollee in crisis in order to reduce symptoms of severe and persistent mental illness or serious emotional disturbance and to prevent admission of the enrollee to a more restrictive environment.

(d) Frequency and duration. The provision of psychosocial rehabilitative services must be in accordance with the amount and duration for which the Medicaid provider has obtained authorization.

D. Skills Training and Development Services.

(a) Description.

(1) Skills training and development services is training provided to an enrollee or the LAR or primary caregiver of a child or adolescent. Such training:

(A) addresses severe and persistent mental illness or serious emotional disturbance and symptom-related problems that interfere with the enrollee's functioning and living, working, and learning environment;

(B) provides opportunities for the enrollee to acquire and improve skills needed to function as appropriately and independently as possible in the community; and

(C) facilitates the enrollee's community integration and increases his or her community tenure.

(2) Skills training and development services include teaching an enrollee the following skills:

(A) skills for managing daily responsibilities (e.g. paying bills, attending school and performing chores);

(B) communication skills (e.g., effective communication and recognizing or change problematic communication styles);

(C) pro-social skills (e.g., replacing problematic behaviors with behaviors that are socially acceptable);

(D) problem-solving skills;

(E) assertiveness skills (e.g., resisting peer pressure, replacing aggressive behaviors with assertive behaviors, and expressing one's own opinion acceptably);

(F) social skills (e.g. selection of appropriate friends and healthy activities);

(G) stress reduction techniques (e.g., progressive muscle relaxation, deep breathing exercises, guided imagery, and selected visualization);

(H) anger management skills (e.g., identification of antecedents to anger, calming down, stopping and thinking before acting, handling criticism, avoiding and disengaging from explosive situations);

(I) skills to manage the symptoms of mental illness and to recognize and modify unreasonable beliefs, thoughts and expectations;

(J) skills to identify and utilize community resources and informal supports;

(K) skills to identify and utilize acceptable leisure time activities (e.g., identifying pleasurable leisure time activities that will foster acceptable behavior); and

(L) independent living skills (e.g. money management, accessing and using transportation, grocery shopping, maintaining housing, maintaining a job, and decision making).

(3) Skills training and development services include training an LAR or primary caregiver to assist the child or adolescent in learning the skills described in paragraph (2) of this subsection.

(b) Conditions.

(1) Skills training and development services may be provided to:

(A) an adult;

(B) a child or adolescent; or

(C) the LAR or primary caregiver of a child or adolescent.

(2) Skills training and development services provided to an adult may be provided:

(A) one-to-one; or

(B) in a group.

(3) Skills training and development services provided to a child or adolescent must be provided one-to-one, except that the LAR or primary caregiver may also be present.

(4) Skills training and development services provided to an LAR or primary caregiver of a child or adolescent must be provided one-to-one, except that the child or adolescent may also be present.

(5) Skills training and development services may be provided:

(A) on-site; or

(B) in-vivo.

(6) Skills training and development services provided to a child or adolescent must be provided according to curricula approved by the State.

(7) Skills training and development services provided to an adult must be provided by:

(A) a QMHP-CS;

(B) a CSSP; or

(C) a peer provider.

(8) Skills training and development services provided to a child or adolescent must be provided by:

(A) a QMHP-CS; or

(B) a CSSP.

(9) Skills training and development services provided to an LAR or primary caregiver of a child or adolescent, must be provided by:

(A) a QMHP-CS; or

(B) a CSSP.

(10) Skills training and development services may not be provided to an enrollee who is currently admitted to a CSU.

(c) Frequency and Duration. The provision of skills training and development services must be in accordance with the amount and duration for which the Medicaid provider has obtained authorization.

E. Day Programs for Acute Needs.

(a) Description. Day programs for acute needs provide short-term, intensive treatment to an enrollee who requires multidisciplinary treatment in order to stabilize

acute psychiatric symptoms or prevent admission to a more restrictive setting. Day programs for acute needs:

(1) are provided in a highly structured and safe environment with constant supervision;

(2) ensure an opportunity for frequent interaction between an enrollee and staff members;

(3) are services that are goal-oriented and focus on:

(A) reality orientation;

(B) symptom reduction and management;

(C) appropriate social behavior;

(D) improving peer interactions;

(E) improving stress tolerance; and

(F) the development of coping skills; and

(4) consist of the following component services:

(A) psychiatric nursing services;

(B) pharmacological instruction;

(C) symptom management training; and

(D) functional skills training.

(b) Conditions.

(1) Day programs for acute needs:

(A) may only be provided to adults;

(B) may be provided in a setting with any number of enrollees; and

(C) may be provided:

(i) on-site; or

(ii) in a short-term, crisis-resolution oriented residential treatment setting that is not:

(I) a general medical hospital;

(II) a psychiatric hospital; or

(III) an IMD.

(2) Except as provided by paragraphs (4) and (5) of this subsection, day programs for acute needs must be provided by:

(A) a QMHP-CS;

(B) a CSSP; or

(C) a peer provider.

(3) Day programs for acute needs must, at all times:

(A) have a sufficient number of staff members to ensure safety and program adequacy; and

(B) at a minimum include:

(i) one RN for every 16 enrollees at the day program's location;

(ii) one physician to be available by phone, with a response time not to exceed 15 minutes;

(iii) two staff members who are QMHP-CSs, CSSPs, or peer providers at the day program's location;

(iv) one additional QMHP-CS who is not assigned full-time to another day program to be physically available, with a response time not to exceed 30 minutes; and

(v) additional QMHP-CSs, CSSPs, or peer providers at the day program's location sufficient to maintain a ratio of one staff member to every four enrollees.

(IV) one additional QMHP-CS who is not assigned full time to another day program, to be physically available, with a response time not to exceed 30 minutes; and

(V) additional QMHP-CSs or CSSPs at the day program's location sufficient to maintain a ratio of one staff member to every four enrollees.

(4) Psychiatric nursing services, as described in subsection (c)(1) of this section, must be provided by an RN at the day program's location.

(5) Pharmacological instruction, as described in subsection (c)(2) of this section, must be provided by a licensed medical personnel.

(c) Components of day programs for acute needs.

(1) Psychiatric nursing services consist of:

(A) a nursing assessment;

(B) the coordination of medical activities (e.g., referrals to specialists and scheduling medical laboratory tests);

(C) the administration of medication;

(D) laboratory specimen collections and screenings (e.g., the Abnormal Involuntary Movement Scale);

(E) emergency medical interventions as ordered by a physician; and

(F) other nursing services.

(2) Pharmacological instruction is training to an enrollee that addresses medication issues related to the crisis precipitating the provision of day programs for acute needs. Such medication issues include:

(A) the role of the enrollee's medications in stabilizing acute psychiatric symptoms or preventing admission to a more restrictive setting;

(B) the identification of substances that reduce the effectiveness of the enrollee's medications;

(C) appropriate interventions to reduce side-effects of the medications and increase the enrollee's compliance with medication treatment; and

(D) the self-administration of the enrollee's medication.

(3) Symptom management training assists an enrollee in recognizing and reducing her or his symptoms and includes training the enrollee on:

(A) the identification of thoughts, feelings, or behaviors that indicate the onset of acute psychiatric symptoms;

(B) developing coping strategies to address the symptoms;

(C) identification of external circumstances that trigger the onset of the acute psychiatric symptoms; and

(D) relapse prevention strategies;

(4) Functional skills training assists an enrollee in acquiring the skills needed to enable the enrollee to continue to reside in the community and avoid more restrictive levels of treatment and includes training the enrollee on:

(A) personal hygiene;

(B) nutrition;

(C) food preparation;

(D) money management;
(E) socially appropriate behavior; and
(F) accessing and participating in community activities.

(d) Frequency and duration. The provision of day programs for acute needs must be in accordance with the amount and duration for which the Medicaid provider has obtained authorization.

F. Documentation Requirements.

(a) General documentation. A Medicaid provider must document the following for all Medicaid MH rehabilitative services:

(1) the name of the enrollee to whom the service was provided;
(2) the type of service provided;
(3) the specific skill(s) trained on and the method used to provide the training;
(4) the date the service was provided;
(5) the begin and end time of the service;
(6) the location where the service was provided;
(7) the signature of the staff member providing the service and a notation as to whether the staff member is an LPHA, a QMHP-CS, a pharmacist, a CSSP, an LVN, or a peer provider; and
(8) any pertinent event or behavior relating to the enrollee's treatment which occurs during the provision of the service.

(b) Service documentation. In addition to the requirements described in subsection (a) of this section, a Medicaid provider must document the following:

(1) for crisis intervention services:
(A) the documentation required by Title 25, TAC, Chapter 412, Subchapter G, §412.314(c) (relating to Documentation of Crisis Services); and
(B) the outcome of the enrollee's crisis;
(2) for medication training and support services and skills training and development services, the name of the primary caregiver or LAR to whom the service was provided, if applicable;
(3) for psychosocial rehabilitative coordination services:
(A) a description of the coordination service provided;
(B) if the service involves face-to-face or telephone contact, the person with whom the contact was made; and
(C) the outcome of the service;
(4) for Medicaid MH rehabilitative services other than crisis intervention services and day programs for acute needs:
(A) a summary of the activities that occurred;
(B) the modality of service provision (i.e. one-to-one or group);
(C) the treatment plan goal(s) that was the focus of the service; and
(D) the progress or lack of progress in achieving treatment plan goal(s); and
(5) for day programs for acute needs, the progress or lack of progress in stabilizing the enrollee's acute psychiatric symptoms.

(c) Frequency of documentation.

(1) For day programs for acute needs, the documentation required by subsections (a) and (b)(5) of this section must be made daily.

(2) For Medicaid MH rehabilitative services other than day programs for acute needs, the documentation required by subsections (a) and (b)(1)-(4) of this section must be made after each face-to-face contact that occurs to provide the Medicaid MH rehabilitative service.

(3) A Medicaid provider must retain documentation in compliance with applicable federal and state laws, rules, and regulations.

G. Staff Member Training.

(a) Training of staff members. A Medicaid provider must provide training to a staff member to ensure competency in the provision of Medicaid MH rehabilitative services. Such training must be provided in accordance with the following:

(1) A staff member who provides Medicaid MH rehabilitative services or supervises the provision of Medicaid MH rehabilitative services must receive training and demonstrate competency in the following areas:

(A) the requirements of this subchapter and of Title 25, TAC, Chapter 412, Subchapter G (relating to the Mental Health Community Services Standards);

(B) the nature of severe and persistent mental illness and serious emotional disturbances;

(C) the dignity and rights of an enrollee in accordance with Chapter 404, Subchapter E of this title (relating to Rights of Persons Receiving Mental Health Services);

(D) identifying, preventing, and reporting abuse, neglect, and exploitation in accordance with Title 25, TAC, Chapter 414, Subchapter L (relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers);

(E) interacting with an enrollee who has a special physical need such as a hearing or visual impairment;

(F) responding to an enrollee's language and cultural needs through knowledge of customs, beliefs, and values of various, racial, ethnic, religious, and social groups;

(G) the uniform assessment;

(H) the utilization management guidelines;

(I) developing and implementing an individualized treatment plan;

(J) identifying an enrollee in crisis;

(K) appropriate actions to take in managing a crisis;

(L) skills training techniques;

(M) the treatment of co-occurring psychiatric and substance use disorders as described in Title 25, TAC, Chapter 411, Subchapter N (relating to Standards for Services to Persons with Co-Occurring Psychiatric and Substance Use Disorders);

(N) the availability of resources within the local community; and

(O) strategies for effectively advocating for an enrollee.

(2) A staff member who routinely provides or supervises the provision of Medicaid MH rehabilitative services to a child or adolescent must receive training and demonstrate competency in the following areas:

(A) the aspects of a child's growth and development (including physical, emotional, cognitive, educational and social) and the treatment needs of a child and adolescent; and

(B) the State's approved skills training curricula.

(3) Except for the direct clinical supervision of a peer provider, which must be provided by an LPHA, the clinical supervision of the provision of Medicaid MH rehabilitative services must be provided by a QMHP-CS.

(b) Frequency. A staff member must receive the training required by subsection (a) of this section before assuming responsibilities in providing or supervising the provision of Medicaid MH rehabilitative services.

(c) Documentation of training. A Medicaid provider must document that a staff member has successfully completed the training and has demonstrated competencies in the areas described in subsection (a) of this section.

H. Medicaid Reimbursement.

(a) Billable and non-billable activities.

(1) A Medicaid provider may only bill for Medicaid MH rehabilitative services that are provided face-to-face to:

(A) an enrollee; or

(B) the LAR or primary caregiver of a child or adolescent.

(2) The cost of the following activities are included in the Medicaid MH rehabilitative services reimbursement rate(s) and may not be directly billed by the Medicaid provider:

(A) developing and revising the treatment plan and interventions that are appropriate to an enrollee's needs;

(B) staffing and team meetings to discuss the provision of Medicaid MH rehabilitative services to a specific enrollee;

(C) monitoring and evaluating outcomes of interventions, including contacts with a person other than the enrollee;

(D) documenting the provision of Medicaid MH rehabilitative services;

(E) a staff member traveling to and from a location to provide Medicaid MH rehabilitative services;

(F) all services provided within a day program for acute needs that are delivered by a staff member, including services delivered in response to a crisis or an episode of acute psychiatric symptoms; and

(G) administering the uniform assessment.

(b) Non-reimbursable activities.

(1) The Contractor will not reimburse a Medicaid provider for any combination of Medicaid MH rehabilitative services, other than crisis intervention services, delivered in excess of 8 hours per enrollee per day. In addition the Contractor will not reimburse a Medicaid provider for more than:

(A) two hours per enrollee per day of medication training and support services;

(B) four hours per enrollee per day of psychosocial rehabilitation services;

(C) four hours per enrollee per day of rehabilitative counseling and psychotherapy;

(D) four hours per enrollee per day of skills training and development services; and

(E) six hours per enrollee per day of day programs for acute needs.

(2) The Contractor will not reimburse a Medicaid provider for:

(A) except for crisis intervention services, a Medicaid MH rehabilitative service that is not included in the enrollee's treatment plan;

(B) a Medicaid MH rehabilitative service that is not authorized;

(C) a Medicaid MH rehabilitative service provided in excess of the amount authorized;

(D) a Medicaid MH rehabilitative service provided outside of the duration authorized;

(E) a psychosocial rehabilitative service provided to an enrollee receiving MH case management services in accordance with Title 25, TAC, Chapter 412, Subchapter I (relating to Mental Health Case Management Services);

(F) a Medicaid MH rehabilitative service that is not documented in accordance with Section II.G of this Appendix;

(G) a Medicaid MH rehabilitative service provided to an enrollee who is not present, awake, and participating during such service; and

(H) any other activity or service identified as non-reimbursable in the DSHS Medicaid MH Rehabilitative Services Billing Guidelines, which is referenced as Exhibit D in Title 25 TAC Chapter 419, Subchapter L, §419.468 (relating to Exhibits).

(c) Services provided same time and same day.

(1) If a Medicaid provider provides more than one Medicaid MH rehabilitative service to an enrollee at the same time and on the same day, the Medicaid provider may bill for only one of the services provided.

(2) A Medicaid provider may bill for a Medicaid MH rehabilitative service provided to a child or adolescent's LAR or primary caregiver at the same time and on the same day the child or adolescent is receiving another Medicaid MH rehabilitative service only if the staff member providing the service to the LAR or primary caregiver is different from the staff member providing the service to the child or adolescent.

(d) Services provided before a fair hearing. If the provision of an Medicaid MH rehabilitative service is continued prior to a fair hearing decision being rendered, as required by Texas Administrative Code, Title 1, §357.7 (relating to Maintaining Benefits or Services), the Medicaid provider may bill for such service.